

Questions On The Colorado Response

Section 2. General Background and Description of State Approach to Child Health Coverage

Section 2.3

1. Colorado's response concerning the use of the Internet is acceptable, as long as the State agrees to comply with any HCFA standards that are developed. We may have some additional guidance in the near future.

The State **agrees** to comply with **any** HCFA standards **that are** developed. We look forward to **working** with HCFA toward **making** eligibility and enrollment processes easier for qualifying families in **all** areas of Colorado.

Section 3. General Contents of State Child Health Plan

Section 3.2

2 Will there be a standard definition of special needs in all managed care contracts? Please clarify whether the State will be defining special needs, and if so, what that definition will be.

The CHP+ HMO contract reads:

A. *"Special Health Care Needs"*

With respect to persons enrolled pursuant to this Contract, shall mean ongoing health conditions that:

1. **have a biological, physiological or cognitive basis;**
2. **have lasted, or are** virtually certain to last, for more than one year, and;
3. **produce one or more of the following sequelae:**
 - a. significant limitation in **areas** of physical, cognitive or emotional **function;**
 - b. **dependency on medical or assistive devices to minimize** limitation or function of activities;
 - c. Significant limitation in social **growth** or developmental **function;**
 - d. need for psychological, educational, medical or related services **over and** above the usual for a child's **age;** or,
 - e. **special** ongoing treatments such as medications, diets, interventions or accommodations at home or **at** school.

B. Members with Special Health Care Needs

- 1. The Contractor agrees to have a mechanism to determine if a Member has Special Health Care Needs. The Contractor agrees to have a system in place to allow the Primary Care Physician (PCP) to provide standing referral for Members with Special Health Care Needs to a specialist, A standing referral will need to be renewed once a year.
- 2. The Contractor must have in place for Members with Special Health Care Needs an adequate network of pediatric Providers and subspecialists, and contractual relationships with tertiary institutions, to meet their medical needs. All Members with Special Health Care Needs must have timely access to:
 - a. Comprehensive evaluation for the condition;
 - b. Pediatric subspecialty consultation and care appropriate to the condition; and,
 - c. Rehabilitative services provided by professionals with pediatric training.
- 3. The Contractor shall use reasonable efforts to encourage Providers to cooperate with and communicate with other service Providers who provide services to the Member with Special Health Care Needs.

The next HMO contract, which will take effect on July 1, 1998, will specify a working relationship between the HCP and the MCOs, not only to provide case management for these children, but for the public agency to pay for treatments and durable medical equipment costs which exceed the basic benefit design.

Section 4. Eligibility Standards and Methodology

Section 4.1.5

The form for determining the date of permanent resident status is correct. However, this information is not indicated in the TEMP RES ADJ DATE that the State has indicated. This field is used only in cases where the alien has not yet received permanent resident status. The date of permanent residence is contained elsewhere on the 1-551. This is the date Colorado needs to use to determine whether or not the child was a permanent resident before 8/22/96. Please correct your procedure.

The entry system for applications requests only the date of permanent resident status. The supporting documentation, however, will contain references to the 1-551 form and it will be updated to reflect that the date for permanent resident status should be drawn from the Date Adjusted to LPR Status section.

Does the State plan to use the evidence provisions of State Medicaid Manual section 3212.41 This section describes the evidence to be used to establish that an individual is a qualified alien. Also, does the State plan to use the SAVE system used by Medicaid to

verification? This system exists to assist States to determine issues such as the date of arrival purposes of the 5 year bar. Since not all qualified aliens are ineligible for the CHIP program needs to know which ones are not in order to provide CHIP benefits.

State does plan to use the evidence provisions of State Medicaid Manual section 3212.4. In the process of creating system (both information systems and paper systems) to implement provisions by March 1, 1998. The State also intends to use the SAVE system used by other states to verify eligibility.

The question contains a double negative. Do you mean to say " Since not all qualified aliens are eligible ELIGIBLE for Medicaid, the CHIP program needs to know which ones are not in order to provide CHIP benefits?" We understand that not all qualified aliens are eligible for Medicaid. Nor are all qualified aliens eligible for CHIP. We would appreciate your guidance on this.

4.4.1

provide a clarifying statement that Colorado will not include income that is exempt from Federal statutes, such as reparation payment.

On the full implementation of the rule-based system, the eligibility staff will screen types of income manually and make a determination of the appropriateness of the exclusion of reparation payments prior to entering the total income reported by the family under "Wage-Work Income." Specific exclusion of reparation payments is contained in the CCHIP Policies and Procedures Manual.

Will appropriate treatment of reparations payments will be simple under the rules-based system. Though income data will be collected for all income types, for the purposes of eligibility determination, income which is excluded by federal statutes will not be included in the determination of total family income. Reparation payments, specifically, are not included in the determination of total family income.

§6. Coverage Requirements for Children's Health Insurance

§6.1

Clarify the effect of the change in the benefit package (dropping the dental benefit and adding one benefit package) on the actuarial analysis. Is the benefit package still actuarially equivalent?

There are still two benefit packages, the FFS and HMO benefit packages. As shown in the attached Revised Actuarial Report, the two new benefit packages are actuarially equivalent.

Sec. Cost Sharing and Payment

Sec.2

The amount for emergency transportation is \$6 and can be waived with a hospital admission. Title XIX regulations allow for the imposition of a maximum copayment of \$6.

or nonemergency use of the emergency room for those persons at or below 150 percent FPL. A hospital admission does not necessarily determine appropriate use of the emergency room. Please clarify this issue,

language has been added to the benefit package which states that the co-pay is waived for emergency visits. Please see the attached benefit schedules.

Section 8.4.2

Please clarify whether Colorado will follow the well-baby and well-child visit schedule and services recommended by the American Academy of Pediatrics. If not, please provide additional information on the schedule and services provided for this group. The chart contained on page 14 should be revised to include annual visits for adolescents ages 14 - 18.

The revised benefit packages include a statement indicating the well care visits and immunizations will be covered as recommended by the American Academy of Pediatrics. Please see the attached benefit schedules.

Section 8.5

The lower premium amounts should be extended through 150 percent of the FPL, to conform with Medicaid requirements. The higher premium amounts can be imposed above 150 percent of the FPL. Please make this adjustment in the text and attachment 4.

Please see the attached revised Premium Schedule that reflects this change. Also, Section 8.5 is revised to read:

Premiums for families through 100% FPL will be waived. For families between 101% and 150% with one child, premiums will be \$9/child/month, and for families with two or more children, \$15/family/month. Between 151% and 169% FPL, families with one child will pay \$15/child/month, and families with two or more children will pay \$25/family/month. For families between 170% and 185% FPL with one child, they will pay \$20/child/month and families with two or more children will pay \$30/family/month. For families above 185% FPL there will be no subsidy.

9. With regard to the 5 percent limit on cost sharing, what occurs when the family reaches the limit? Can the family stop payment of premiums and cost sharing when they reach this limit, or is the family required to continue payment until the end of the year? If the family is required to continue payment, would the State consider changing the program to allow payment of premiums and cost sharing to terminate at the 5 percent level? Is the 5 percent income limit based on the income level determined at eligibility or actual income earned during the period? Please describe experience with this "shoe-box" approach related to the Colorado Indigent Care Program.

Families will be required to track their expenditures. Once they submit evidence that they have exceeded the 5% cap, the state will issue them a "Co-pay Exempt" sticker for them to place on their membership card. Providers and plans will be informed that enrollees with this sticker will not be charged a co-pay for any service.

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The 5% limit will be calculated on the family's income derived at the time of eligibility termination. The cap will be recalculated if a family applies for a redetermination before the year is complete.

0. Attached is the budget document which shows the sources of non-federal funding for the program.

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**Revised
Actuarial Report**

Child Health Plan Plus

January 1998

**Revised
Actuarial Report**

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Actuarial Report**

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Revised Actuarial Report
Child Health Plan Plus
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Background

This revised actuarial report was developed at the request of the Colorado Department of Health Care Policy and Financing by *Leif Associates, Inc.*, an independent actuarial consulting firm. The purpose of the report is to supplement the State of Colorado's application for Federal funds under Title XXI of the Social Security Act for the Child Health Plan Plus.

Title XXI, Section 2103, specifies that the scope of health insurance coverage under this program must consist of either benchmark coverage, benchmark-equivalent coverage, existing comprehensive state-based coverage, or Secretary-approved coverage. Certain actuarial values must be set forth in an actuarial opinion in an actuarial report to accompany the State's application. Those actuarial values include the following:

- The actuarial value of the coverage provided by the benchmark benefit packages;
- The actuarial value of the coverage offered under the State child health plan;
- The actuarial value of the coverage of any categories of additional services under benchmark benefit packages; and,
- The actuarial value of any categories of additional services under coverage offered by the State child health plan.

This actuarial report includes the actuarial values listed above, along with supporting documentation and other information. It is a revision of the actuarial report submitted in October 1997. The revision is necessary due to changes that have been made in the plan design for the Colorado plan subsequent to the earlier actuarial report.

Benchmark Benefit Packages

The benchmark benefit packages identified in Title XXI, Section 2103, are as follows:

- FEHBP-equivalent children's health insurance coverage. This is described as the standard Blue Cross/Blue Shield preferred provider option service benefit plan, described in and offered under section 8903(1) of title 5, United States Code.

The Blue Cross/Blue Shield preferred provider option service benefit plan is composed of an in-network benefit and an out-of-network benefit package. As stated in FEHBP documentation, the non-PPO benefits are the standard benefits of the plan. PPO benefits apply only when the covered person uses a PPO provider. Therefore, the non-PPO benefits of the FEHBP plan were used in this study to determine the actuarial value of FEHBP coverage.

- State employee coverage. This is described as a health benefits coverage plan that is offered and generally available to State employees in the State involved.

The State of Colorado currently offers five HMO and three self-funded health benefit plans for its employees to choose from. The plan that currently has the largest enrollment is known as the Exclusive Path. This plan covers approximately 15,000 State employees and their dependents, out of a total of approximately 28,000 State employees that are covered under the State's employee health benefit plans. The Exclusive Path uses a large network of health care providers, and coverage is

provided **only** when care **is secured** from those providers. It **has** the typical **plan design** features of an HMO plan. **Fur** purposes of this **study**, the Exclusive Path **was chosen as** the benchmark state employee benefit coverage,

- **Coverage offered through an HMO.** This is described as the health insurance coverage plan that:

~~(A) is offered by a health maintenance organization (as defined in section 2791 (b)(3) of the Public Health Service Act), and~~

(B) has the largest insured commercial, non-Medicaid enrollment of covered lives of such coverage plans offered by such a health maintenance organization in the State involved.

In order to determine the HMO benchmark coverage for Colorado, an informal survey of the largest HMOs in the state was conducted by the Colorado Department of Health Care Policy and Financing. Based on this informal survey, it was determined that the HMO plan that has the largest insured commercial, non-Medicaid enrollment of covered lives in Colorado is the Kaiser Foundation Health Plan of Colorado Plan 710, with pharmacy, durable medical equipment, and optical riders. This plan was used as the benchmark HMO coverage for purposes of this study.

A plan design grid, which shows the details of the benefits of these three benchmark plans, is attached to this report and labeled as Exhibit I.

Child Health Plan Plus Benefit Packages

The benefit structure for the Child Health Plan Plus will vary depending on whether HMO plans are available. The fee-for-service program will be available in areas where no HMO coverage is available.

The proposed HMO Child Health Plan Plus includes three separate benchmark-equivalent benefit packages. One is for children in families below 101% of the Federal poverty level who do not otherwise qualify for Medicaid coverage. Another is for children in families between 101% and 150% of the Federal poverty level. The third is for children in families between 151% and 185% of the Federal poverty level. The plans each provide coverage for the same health care services. The only difference between the three plans is the level of cost sharing. Copayments, when required, are higher for participants with higher family incomes.

A plan design grid, which shows the details of all four Child Health Plan Plus benefit packages, is attached to this report and labeled as Exhibit II. The coverage includes benefits for items and services within each of the categories of basic services described in Section 2103.

Methodology for Determining Actuarial Equivalency

In order to determine the actuarial equivalency of the proposed **Child Health Plan Plus** benefit packages to the benchmark plans, the following methodology was used.

- **Identification of a standardized set of utilization and price factors.**

The **standardized** set of **utilization and** price factors used to determine the actuarial equivalency of the Child Health **Plan**. Plus to the benchmark plans is set forth in Exhibit III of this report. These standardized utilization **and** price factors have **the following** characteristics:

- 1) **The factors were based** on a compilation of data **from** a number of unpublished sources;
- 2) **The factors were** adjusted to reflect weighted statewide Colorado health **care** utilization and costs, **rather than those for** a specific geographic location within Colorado;

- 3) The factors represent the unique health care utilization and cost patterns for children, rather than adults or the combination of children and adults;
- 4) The factors were developed for children at various ages and weighted using the standardized population of children described below to arrive at combined average factors for children under nineteen years of age;
- 5) The factors were projected to mid-year 1998, using typical utilization and cost trend;;
- 6) The factors were based on typical insured coverage utilization and costs in a traditional fee-for-service environment with limited utilization management;
- 7) The development of the factors involved considerable actuarial judgement.

▪ Identification Of a standardized population.

The standardized population used to determine the actuarial equivalency of the Child Health Plan Plus to the benchmark plans is set forth in Exhibit IV of this report. This standardized population is the projected 1997 Colorado population by single age for children ages 0 through 18, as determined by the U.S. Bureau of the Census, Population Projections Branch. This standardized population is believed to be representative of the distribution of privately insured children of the age of children who are expected to be covered under the State child health plan.

▪ Calculation of the actuarial value of the benchmark plans and the categories of additional services included in the benchmark plans.

Based on the standardized set of utilization and cost factors and the standardized population described above, the aggregate actuarial value and the actuarial value of categories of additional services provided by the three benchmark benefit plans was determined. The actuarial values, stated in terms of average monthly claim costs, are set forth below.

	Coverage	Coverage	Coverage
Aggregate Actuarial Value	\$ 74.35	\$ 81.81	\$ 82.71
Additional Services Actuarial Value			
Prescription Drugs	\$ 4.11	\$ 4.53	\$ 6.11
Mental Health Services	\$ 6.39	\$ 6.50	\$ 6.34
Vision Services	\$ -0-	\$ 0.70	\$ 0.92
Hearing Services	\$ -0-	\$ 0.29	\$ 0.19

▪ Calculation of the actuarial value of the Colorado plans and the categories of additional services included in the Colorado plans.

Based on the standardized set of utilization and cost factors and the standardized population described above, the aggregate actuarial value and the actuarial value of categories of additional services provided by the proposed Colorado plans was determined. The actuarial values, stated in terms of average monthly claim costs, are set forth below

	Fee-For-Service Plan	HMO Plans		
		Below 101% FPL	Between 101% and 150% FPL	Between 151% and 185% FPL
Aggregate Actuarial Value	\$ 87.52	\$ 89.74	\$ 88.97	\$ 87.61
Additional Services Actuarial Value				
Prescription Drugs	\$ 6.67	\$ 7.04	\$ 6.86	\$ 6.22
Mental Health Services	\$ 6.63	\$ 6.66	\$ 6.63	\$ 6.60
Vision Services	\$ 1.04	\$ 1.06	\$ 1.04	\$ 1.00
Hearing Services	\$.65	\$ 0.65	\$ 0.65	\$ 0.65

In calculating the actuarial values stated above, the same actuarial principles and standardized factors were used in comparing the value of different coverage and categories of services, without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used.

The cost sharing reflected in the benefit structure for participants below 150% of Federal poverty level meets the requirements stated in Section 2103(e)(3). The copayments for participants between 151% and 185% of Federal poverty level are minimal, and when combined with the proposed premium payments for the program, are not expected to result in cost sharing that exceeds 5% of family income. Therefore, it is expected that the actuarial values shown above will not be increased because of cost sharing limitations which might otherwise result in an increase in the actuarial value of the plans.

It is important to recognize that the actuarial values developed from the standardized utilization and cost factors in this report do not represent the actual expected costs of the Child Health Plan Plus. The program is expected to include significant utilization management and negotiated provider reimbursements through the implementation of HMO contracts. It is also expected that the age distribution of children enrolled in the plan will not mirror that of privately insured children, as reflected in the Colorado population projections. Assumptions regarding the cost impact of managed care approaches and the actual expected enrollment distribution are not included in this report.

Determination of actuarial equivalence of the Colorado plans to the benchmark plans.

The proposed Child Health Plan Plus benefit packages have an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages. The actuarial value of these benefit packages exceeds the actuarial value of all three benchmark benefit packages.

With respect to each of the categories of additional services described in Section 2103, the proposed Child Health Plan Plus benefit packages have an actuarial value that is equal to at least 75 percent of the actuarial value of the coverage of that category of services in the benchmark packages. The actuarial value of these additional services exceeds the actuarial value of the corresponding additional service in each of the three benefit plans. A summary table is shown below.

	Benchmark Plans			Colorado Plans			
	FEHBP Coverage	State Employee Coverage	HMO Coverage	Fee-For-Service Plans	HMO Below 101% FPL	HMO Between 101% and 150% FPL	HMO Between 151% and 185% FPL
Aggregate Actuarial Value	\$74.35	\$ 81.81	\$ 82.71	\$ 87.52	\$ 89.74	\$ 88.97	\$ 87.61
Additional Services Actuarial Value							
Prescription Drugs	\$ 4.21	\$ 4.53	\$ 6.11	\$ 6.67	\$ 7.04	\$ 6.86	\$ 6.22
Mental Health Services	\$ 6.39	\$ 6.50	\$ 6.54	\$ 6.63	\$ 6.66	\$ 6.63	\$ 6.60
Vision Services	\$ -0-	\$ 0.70	\$ 0.92	\$ 1.04	\$ 1.06	\$ 1.04	\$ 1.00
Hearing Services	\$ -0-	\$ 0.29	\$ 0.19	\$.65	\$.65	\$.65	\$.65

Report Preparation

Elizabeth J. Leif, Consulting Actuary and President of Leif Associates, Inc., a private actuarial consulting firm, prepared this actuarial report. Ms. Leif is a Fellow of the Society of Actuaries, a Fellow of the Conference of Consulting Actuaries, and a member of the American Academy of Actuaries.

Actuarial Opinion

I, Elizabeth J. Leif, a member of the American Academy of Actuaries, have performed the actuarial calculations described in this report and prepared the report and supporting documentation. It is my opinion that:

- The report has been prepared using generally accepted actuarial principles and methodologies;
- The report has been prepared in accordance with the principles and standards of the Actuarial Standards Board for such reports;
- A standardized set of utilization and price factors has been used;
- A standardized population that is representative of privately insured children of the age of children who are expected to be covered under the Child Health Plan Plus has been used
- The same principles and factors have been applied in comparing the value of different coverage (or categories of services);
- Differences in coverage based on the method of delivery or means of cost control or utilization used have not been taken into account;
- The ability of the State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under the Child Health Plan Plus that results from the limitations on cost sharing under such coverage has been taken into account.

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Child Health Plan Plus
Benchmark Benefit Packages

Category	1997 FENBP - Standard BCBS PPO Plan		1997 Colorado State Employee Coverage - Exclusive Path	HMO Plan - Kaiser Permanente Plan 710
	PPO	Non-PPO ¹		
ANNUAL DEDUCTIBLE Individual Family	\$200 per person ² \$400 per family		None	None
COINSURANCE	95%	75%	100%	100%
OUT-OF-POCKET Individual Family	\$2,000 \$2,000	\$3,750 \$3,750	None	None
HOSPITAL AND EMERGENCY ROOM TRANSPORT	After \$200 calendar year deductible, plan pays 75% of the allowable charge		Up to a \$500 maximum benefit for ground ambulance; UP to a \$4,000 maximum benefit for air ambulance	
INPATIENT	\$250 deductible per admission; ³		\$150 copay per admission	
	100% coinsurance after per admission deductible	70% coinsurance after per admission deductible		
INPATIENT PHYSICIAN CARE	95% coinsurance after the \$200 calendar year deductible	75% coinsurance after the \$200 calendar year deductible	Paid in full	Paid in full
OUTPATIENT FACILITY CARE	After \$200 calendar year deductible, plan pays in full, subject to \$25 (PPO) or \$100 (Member facility) copayment per facility per day	After \$200 calendar year deductible, plan pays in full, subject to \$150 copayment per facility per day	\$75 copay per emergency room visit; \$25 copay per physician emergency room visit	\$10 copay each visit; \$50 copay for emergency services received inside the service area from non- plan providers
OUTPATIENT SURGERY	Plan pays in full, subject to \$25 (PPO) or \$100 (Member facility) copayment	Plan pays in full, subject to \$150 copayment	\$10 copay per visit	\$10 copay per visit
ACCIDENTAL INJURY	Plan pays 100% of covered charges within 72 hours after accidental injury for hospital outpatient care		Paid same as illness	Paid same as illness
MEDICAL OFFICE OR HOME VISIT	\$10 copayment for each outpatient office visit charge	75% coinsurance after the \$200 calendar year deductible	\$10 copay per visit	\$10 copay per visit
LABORATORY & X- RAY SERVICES	Covered at outpatient facility care rates for X-ray, laboratory, pathological services, and machine diagnostic tests		Paid in full	Paid in full
ALLERGY TESTS, TEST MATERIALS, AND TREATMENT MATERIALS	After the \$200 calendar year deductible, plan pays 95% (PPO) or 75% (PAR or non-participating physician)		\$10 copay per visit	\$10 copay per visit
PREVENTIVE CARE	Paid at outpatient facility care rates for cervical cancer screening, mammogram for breast cancer screening, fecal occult blood test for colorectal cancer screening, PSA for prostate cancer screening, tetanus-diphtheria booster, and immunization for influenza and pneumonia		\$5 copay for certain services; ⁴ no payment required for routine mammograms according to age- specific guidelines or prostate screening	Immunizations medically indicated and consistent with accepted medical practice are provided without charge

¹ The non-PPO benefits are the standard benefits of this plan. PPO benefits apply only when you use a PPO provider. When no PPO

provider is available, non-PPO benefits apply.

² Calendar year deductible applies to all covered services and supplies except for certain inpatient hospital benefits, facility benefits - outpatient surgery, additional benefits, prescription drug benefits, and dental benefits.

³ Must be precertified; benefits will be reduced by \$500 if emergency admission is not precertified within two business days following the day of admission;

⁴ Immunizations as recommended by American Academies of Pediatrics and Family Physicians, routine gynecological exams twice each year, age-specific routine physical examinations, and routine vision examinations.

Exhibit I

Benefit Category	1997 FEHBP – Standard BCBS PPO Plan		1997 Colorado State Employee Coverage – Exclusive Path	HMO Plan – Kaiser Permanente Plan 710
	PPO	Non-PPO ¹		
WELL CHILD CARE	For children up to age 12, plan pays 100% of the allowable charge for all healthy newborn inpatient physician visits, and routine physical exams, lab tests, immunizations, and related office visits as recommended by the American Academy of Pediatrics		\$5 copay for certain services	\$10 copay per visit
MATERNITY CARE Prenatal	Plan pays in full	After the \$200 calendar year deductible, plan pays 75%	\$10 copay per office visit	\$10 copay per office visit
Delivery & inpatient well baby care	Pays in full for unlimited days with no per admission deductible (PPO hospital) or after \$250 per admission deductible (Member hospital)	After the \$250 per admission deductible, plan pays 70%	\$150 copay per admission	No charge
INFERTILITY DIAGNOSIS AND TREATMENT	75% coinsurance after the \$200 calendar year deductible	75% coinsurance after the \$200 calendar year deductible	\$10 copay per office visit; covered up to \$15500 per calendar year ³	Medical services are provided with \$10 copay per visit. Artificial insemination is covered, except for donor semen, donor eggs, and services related to procurement and storage. All other services related to conception by artificial means, prescription drugs related to such services are not covered. ⁶ Infertility drugs covered with a 50% charge
ABORTION	Benefits will not be paid for procedures, services, drugs, and supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of rape or incest		Covered only if there is a medical condition that threatens the mother's life if the pregnancy continues, a lethal medical condition in the unborn child that would cause the death of the unborn child during pregnancy or at birth, or a psychiatric condition that may seriously threaten the mother's life if the pregnancy continues to term	

³ Covers artificial insemination in vivo. Does not cover any cost associated with donor sperm or any other service, supply, or drug used with or for an artificially induced pregnancy, such as "test tube" fertilization, drug-induced ovulation, or other artificial means of conception.

⁶ Does not cover in vivo fertilization, ovum transplants, gamete intrafallopian transfer, and zygote intrafallopian transfer.

Exhibit I

Benefit Category	1997 FEHBP Standard BCSPPO Plan		1997 Colorado State Employee Coverage Exclusive Path	HMO Plan - Kaiser Permanente Plan 710
	PPO	Non-PPO ⁷		
ALL OTHER MENTAL HEALTH				
Inpatient care	After a \$150 (PPO) or \$250 (Member hospital) copayment, plan pays the remainder UP to 100 days	After a \$400 per day copayment, plan pays the remainder of the cost up to 100 days	\$150 copayment, then 100% up to 45 days per calendar year	1 - 20 days, no charge; 21 - 45 days, 50%
Inpatient physician visits	After the \$200 calendar year deductible, plan pays 60% of the allowable charge			No charge
Outpatient facility care	After the \$200 calendar year deductible, plan pays in full, subject to \$25 (PPO) or \$100 (Member facility) copayment	After the \$200 calendar year deductible, plan pays in full, subject to \$130 copayment		
Professional care	After the \$200 calendar year deductible, plan pays 60% of the allowable charge; limited to 25 visits per person per calendar year		\$10 copayment per visit, then 100%	1 - 10 visits, \$10 each visit, 11 or more visits, \$25 each visit
ALCOHOL & SUBSTANCE ABUSE	Inpatient: one treatment program (28-day maximum) per person per lifetime; covered at the same levels as hospital care and inpatient visits for mental conditions; outpatient also subject to the same levels as mental conditions		Same as mental health	Inpatient detoxification: same as other hospitalization. Inpatient rehab: only evaluation and referral are covered. Outpatient: 50% covered up to \$650 per 12 month period
ORGAN TRANSPLANTS	After the \$200 calendar year deductible, plan pays 95% (PPO) or 75% (PAR or non-participating) <ul style="list-style-type: none"> ▪ Allogeneic bone marrow⁷ ▪ Autologous bone marrow and autologous peripheral stem cell support⁸ ▪ Allogeneic bone marrow and allogeneic peripheral stem cell support for multiple myeloma and autologous bone marrow and autologous peripheral stem cell support⁹ ▪ Single or double lung transplants for end-stage pulmonary diseases¹⁰ ▪ Cornea ▪ Kidney ▪ Heart ▪ Liver ▪ Heart-lung ▪ Pancreas 		100% of covered expenses, including organ procurement and acquisition. ¹¹ Kidney and cornea require a \$10 copay per office visit and a \$150 per admission hospital copay <ul style="list-style-type: none"> ▪ Heart ▪ Heart-lung ▪ Kidney-pancreas ▪ Pancreas ▪ Liver ▪ Bone marrow [allogeneic and autologous]¹² ▪ Peripheral blood stem cell ▪ Kidney ▪ Cornea Travel expenses for transportation, lodging and meal expenses at 100% up to a total maximum of \$10,000 for a child transplant recipient ¹³	Covered transplants are: <ul style="list-style-type: none"> ▪ Kidney ▪ Heart ▪ Heart-lung ▪ Liver ▪ Lung ▪ Cornea ▪ Kidney/pancreas ▪ Bone marrow transplants associated with high dose chemotherapy for germ cell tumors and neuroblastoma in children are covered. ▪ Bone marrow transplants associated with high dose chemotherapy for other solid tissue tumors are not covered

⁷ For acute lymphocytic or nonlymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma, chronic myelogenous leukemia, infantile malignant osteonetrosis, severe combined immunodeficiency, Wilms

Benefit Category			1997 Colorado State Employee Coverage - Exclusive Path	HMO Plan - Kaiser Permanente Plan 710
	PPO	Non-PPO ¹		
DURABLE MEDICAL EQUIPMENT			Covered at 100%, no annual maximum; includes artificial arms, leg, or eyes, leg braces, arm and back braces, maxillofacial prosthesis, cervical collars, surgical implants, oxygen and equipment needed to administer it, and insulin pumps and related supplies	Covered with 20% copayment, including oxygen and orthotic and prosthetic devices
PHYSICAL AND OCCUPATIONAL THERAPY	After \$200 calendar year deductible, plan pays 75% up to 50 visits for physical therapy and 25 visits for occupational and speech therapy per person per calendar year		\$10 copay per visit for independent therapists; no payment required for hospital outpatient therapy	\$10 copay per visit up to 2 months per condition, or up to 30 visits per condition if not received within 2 months
HOME HEALTH CARE	After the \$200 calendar year deductible, plan pays 75% for home nursing care for up to 2 hours per day up to 25 visits per calendar year		Paid at 100%, up to 60 visits per year	No charge
HOSPICE CARE				
Home	Plan pays in full for member with life expectancy of six months or less for physician visits, nursing care, medical social services, physical therapy, services of home health aides, durable medical equipment rental, prescription drugs, and medical supplies		Paid at 100%, \$8,100 benefit payment limit during a 3-month period. Paid at no less than \$91 per day	No charge
Hospital	Up to 5 consecutive days if receiving home hospice care; must be separated by at least 21 days and is paid in full with no (PPO) or 2250 (**on-member hospital) per admission deductible		Paid at 100%, after \$150 per admission copayment, up to 30 days	No charge
Bereavement Support	Not covered		Up to \$1,053 per family per calendar year	No charge
OUTPATIENT PRESCRIPTION DRUGS	\$50 per person annual deductible, then 80% coinsurance; \$100 family annual deductible; \$12 per prescription copay for mail service prescription drug program ¹⁴	\$50 per person annual deductible, then 60% coinsurance, \$100 family annual deductible	\$10 generic, \$14 brand name plus cost difference between brand and generic if generic is available and not prescribed "dispense as written." \$10 per brand name if generic equivalent exists	\$5 copay per prescription for up to a 60-day supply.

Aldrich syndrome, mucopolysaccharidosis, mucopolipidosis, severe or very severe aplastic anemia, advanced forms of myelodysplastic syndromes, and thalassemia major,

⁸ For acute lymphocytic or nonlymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma, testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors, and multiple myeloma.

⁹ For breast cancer and epithelial ovarian cancer, only when performed as part of a clinical trial that meets the requirements and is conducted at a cancer research facility.

¹⁰ Pulmonary fibrosis, primary pulmonary hypertension, and emphysema; double lung transplant for end-stage cystic fibrosis.

¹¹ Does not cover solid organ transplant in patients with an existing or recent malignancy, excluding hepatomas less than 5 cm in diameter, or patients with carcinoma.

¹² Does not cover bone marrow transplantation (allogeneic and autologous) for melanomas, colon cancers, AIDS, certain brain tumors, testicular cancer, sarcomas, lung cancer, ovarian cancer, and peripheral neuroepithelioma. Does not cover autologous bone marrow transplant and peripheral blood stem cell transplant for chronic myelogenous leukemia, multiple myeloma, or brain metastases.

¹³ Cover\$ expenses incurred by both the child transplant recipient and up to two adults accompanying the transplant recipient.

¹⁴ Drugs obtained through the mail service prescription drug program are not subject to any deductible.

Exhibit I

Benefit Category	1997 FEHBP - Standard BCBS PPO Plan		1997 Colorado State Employt Coverage - Exclusive Path	HMO Plan - Kaiser Permanente Plan 710
	PPO	Non-PPO ¹		
CONTRACEPTIVE DEVICES AND DRUGS	<ul style="list-style-type: none"> IUDs, Norplant, Depo-Provera, and oral contraceptives obtained from a physician are covered at 95% or 75% after \$200 deductible IUDs, Norplant, Depo-Provera, and oral contraceptives dispensed by a retail pharmacy are covered as prescription drugs Oral contraceptives are also covered under the mail service prescription drug program 		The plan covers oral contraceptives, birth control shots, and certain contraceptive devices and their insertion. Does not cover Norplant device and related expenses	Oral contraceptives are covered. Norplant is covered at a charge of \$200, with no refund if the drug is removed. Contraceptive devices are provided at reasonable charges
SKILLED NURSING FACILITY CARE	When Medicare Part A is primary, plan provides secondary benefits for Medicare Part A copayment incurred in full during the 1 st through 30 th day		Not covered	No charge up to 100 days per calendar year
VISION SERVICES	After \$200 deductible, plan pays 75% for one set of eyeglasses or contact lenses required as a result of a single instance of intra-ocular surgery or injury		Routine eye exams covered at 100% after a \$5 office copayment, once every 24 months. No allowance for lensed frames. One set of prescription eyeglasses or contact lenses are covered when needed to replace human lenses absent at birth or lost through intra-ocular surgery or eye injury or for treatment for keratoconus	\$10 copay per visit for eye exams for glasses; each 24 months, one pair of lenses, frames up to \$65, contact lenses up to \$100
HEARING SERVICES			Hearing exams paid at 100%, after a \$5 copayment. Up to \$500 hearing aid allowance once every 3 years	Hearing exams covered with \$10 copay per visit
DENTISTRY	Oral and maxillofacial surgery, limited to listed procedures ¹⁵ . Plan pays 75% after \$200 calendar year deductible for services, supplies, or appliances for accidental injury to sound natural teeth; scheduled amount for other dental care		Covered only if treated in a hospital or other facility on either an inpatient or outpatient basis for certain conditions. ¹⁶ Benefits based on surgery benefits	Coverage is not provided for dental care and x-rays, dental services following accidental injury to teeth, dental appliances, orthodontia, and dental services associated with medical treatment. Coverage is provided for medically necessary services for the treatment of cleft lip or palate for newborn members, unless the member is covered for these services under a dental insurance policy
LIFETIME MAXIMUM	Only for smoking cessation and substance abuse		None	None
SMOKING CESSATION TREATMENT PROGRAM	\$100 per person per lifetime for one program		Not covered ¹	Covered with a reasonable charge

¹⁵ Excision of tumors and cysts, surgery intended to correct accidental injuries, excision of exostoses of jaws and hard palate, external incision and drainage of cellulitis, incision and surgical treatment of accessory sinuses, salivary glands or ducts, reduction of dislocations and excision of temporomandibular joints, and removal of impacted teeth.

¹⁶ Excision of exostoses of the jaw, surgical correction of accidental injuries, incision and drainage of cellulitis, incision of accessory sinuses, salivary glands, or ducts, tumors of the jaw, accident-related dental expenses, orthognathic surgery when required because of a malocclusion of the jaw, and TMJ-related services up to \$1,000 per calendar year.

Exhibit I

Benefit Category	1997 FEHBP - Standard HCBP PPO Plan		1997 Colorado State Employee Coverage - Exclusive Path	HMO Plan - Kaiser Permanente Plan 710
	PPO	Non-PPO		
EXCLUSIONS	<ul style="list-style-type: none"> If no charge would be made if individual had no health insurance coverage Furnished without charge While in active military service Sustained as result of act of war or during combat Furnished by immediate relatives or household members Furnished by provider barred from FEHBP program Furnished by a non-covered facility, except that medically necessary prescription drugs are covered For or related to sex transformation, sexual dysfunction, or sexual inadequacy Not specifically listed as covered Experimental or investigational, except for the clinical trials benefit Not provided in accordance with accepted professional medical standards in the U.S. Any portion of fee that has been waived Charges the enrollee or plan has no legal obligation to pay In the case of inpatient care, medical services which are not medically necessary Standby physicians Biofeedback and other forms of self-care or self-help training, including cardiac rehab Orthodontic care, the teeth, dental implants, periodontal disease, or preparing the mouth for dentures Custodial care Services and supplies furnished or billed by an extended care facility, nursing home, or other non-covered facility, except as specifically described Eyeglasses, contact lenses, routine eye exams or vision testing for the prescribing or fitting of eyeglasses or contact lenses Eye exercises, visual training, or orthoptics, except for non-surgical treatment of amblyopia and strabismus Hearing aids or examinations for the prescribing or fitting of hearing aids Treatment of obesity, weight reduction, or dietary control, except for gastric bypass surgery or gastric stapling procedures Personal comfort items such as beauty and barber services, radio, television, or telephone Services or supplies for cosmetic purposes Routine services, except for those preventive services specifically identified Routine foot care Recreational or educational therapy Assisted Reproductive Technology procedures, such as artificial insemination, in vitro fertilization, embryo transfer, and GIFT Services rendered by non-covered providers such as chiropractors, except in medically under-served areas Procedures, services, drugs, and supplies related to abortions, except when the life of the mother would be endangered or result of rape or incest Inpatient private duty nursing Radial keratotomy Reversal of surgical sterilization Marital, family, educational, or other counseling or training services 		<ul style="list-style-type: none"> Custodial care Maintenance care Any care that is not preauthorized Hypnosis or hypnotherapy treatment Any treatment that is not medically necessary Treatments considered experimental and/or investigational and/or unproven Treatment of nicotine or caffeine addiction Services and related expenses for weight loss program Nutritional supplements Acupuncture Genetic counseling Norplant device and related expenses Rehabilitation for learning disorders, stuttering, short- and long-term memory therapy, or behavior modification Cognitive therapy services Personal comfort and convenience items Cosmetic surgery Sex-change operations Sterilization reversal Radial keratotomy Attention deficit disorder Biofeedback Chiropractic services Hair loss Private duty nursing Skilled nursing facilities Workers' Comp 	<ul style="list-style-type: none"> employer responsibility Custodial or intermediate level care Cosmetic services Dental services and X-rays including services following accidental injury to teeth or surgery on the jaw Physical exams for employment or insurance Experimental or investigational services Services not generally and customarily available Sex transformations Routine foot care not medically necessary Chiropractic services Services for members confined in criminal justice institutions Refractive eye surgery Long-term rehabilitation Pulmonary rehabilitation Food products for enteral feedings Directed blood donations Reversal of voluntary, surgically induced infertility

**Child Health Plan Plus
Colorado Benefit Plans**

Benefit Category	Fee-For-Service Plan	HMO Plan Families <101% FPL	HMO Plan Families 101% FPL to 150% FPL	HMO Plan Families 151% FPL to 185% FPL
ANNUAL DEDUCTIBLE		None	None	None
OUT-OF-POCKET MAXIMUM	5% of annual family income adjusted for family size.	None	5% of annual family income adjusted for family size.	5% of annual family income adjusted for family size.
HOSPITAL EMERGENCY ROOM AND EMERGENCY TRANSPORT (COMBINED) INPATIENT	\$6 copay emergency room; emergency transport not covered	Paid in full	\$6 copay, waived if admitted	\$6 copay, waived if admitted
INPATIENT PHYSICIAN CARE	Paid in full	Paid in full	Paid in full	Paid in full
OUTPATIENT PHYSICIAN CARE	Paid in full	Paid in full	Paid in full	Paid in full
OUTPATIENT SURGERY	Paid in full	Paid in full	Paid in full	Paid in full
ACCIDENTAL INJURY	Paid same as illness	Paid same as illness	Paid same as illness	Paid same as illness
MEDICAL OFFICE OR HOME VISIT	\$2 copay per visit	Paid in full	\$2 copay per visit	\$5 copay per visit
LABORATORY & X-RAY SERVICES	Paid in full	Paid in full	Paid in full	Paid in full
ALLERGY TESTS, TEST MATERIALS, AND TREATMENT MATERIALS	\$2 copay per visit	Paid in full	\$2 copay per visit	\$5 copay per visit
PREVENTIVE CARE	Paid in full	Paid in full	Paid in full	Paid in full
WELL CHILD CARE	Paid in full	Paid in full	Paid in full	Paid in full
INTERIMITY CARE prenatal	Paid in full	Paid in full	Paid in full	Paid in full
Delivery & inpatient well baby care	Paid in full	Paid in full	Paid in full	Paid in full
MENTAL HEALTH (Other Than Neurobiologically Based Illnesses) inpatient care	Paid in full up to 45 days per calendar year	Paid in full up to 45 days per calendar year	Paid in full up to 45 days per calendar year	Paid in full up to 45 days per calendar year
outpatient care	\$2 copay, 20 visit limit	Paid in full	\$2 copay, 20 visit limit	\$5 copay, 20 visit limit
ALCOHOL & SUBSTANCE ABUSE	\$2 copay, 20 visit limit	Paid in full, 20 visit limit	\$2 copay, 20 visit limit	\$5 copay, 20 visit limit
ORGAN TRANSPLANTS	Not covered	Covered transplants are: <ul style="list-style-type: none"> • Liver • Heart • Heart/lung • Cornea • Kidney • Bone marrow for aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and stage III breast cancer, and Wiscott Aldrich syndrome • Peripheral stem cell support for same conditions 	Covered transplants are: <ul style="list-style-type: none"> • Liver • Heart • Heart/lung • Cornea • Kidney • Bone marrow for aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and stage III breast cancer, and Wiscott Aldrich syndrome • Peripheral stem cell support for same conditions 	Covered transplants are: <ul style="list-style-type: none"> • Liver • Heart • Heart/lung • Cornea • Kidney • Bone marrow for aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and stage III breast cancer, and Wiscott Aldrich syndrome • Peripheral stem cell support for same conditions

Exhibit II

Benefit Category	Fee-For-Service Plan	HMO Plan Families < 101% FPL	HMO Plan Families 101% FPL to 150% FPL	HMO Plan Families 151% FPL to 185% FPL
DURABLE MEDICAL EQUIPMENT	Paid in full up to \$2,000 per year	Paid in full up to \$2,000 per year	Paid in full up to \$2,000 per year	Paid in full up to \$2,000 per year
PHYSICAL AND OCCUPATIONAL THERAPY	\$2 copay, up to 30 visits per year	Paid in full, up to 30 visits per year	\$2 copay, up to 30 visits per year	\$5 copay, up to 30 visits per year
HOME HEALTH CARE	Paid in full	Paid in full	Paid in full	Paid in full
HOSPICE CARE	Not covered	Paid in full	Paid in full	Paid in full
OUTPATIENT PRESCRIPTION DRUGS	\$2 copay per prescription	Paid in full	\$1 copay per prescription	\$3 generic, \$5 brand name copay per prescription
SKILLED NURSING FACILITY CARE	Not covered	Paid in full	Paid in full	Paid in full
VISION SERVICES	\$2 copay per visit, \$50 annual benefit for eyeglasses	Paid in full, \$50 annual benefit for eyeglasses	\$2 copay per visit, \$50 annual benefit for eyeglasses	\$5 copay per visit, \$50 annual benefit for eyeglasses
HEARING SERVICES	Paid in full, up to \$800 per year	Paid in full, up to \$800 per year	Paid in full, up to \$800 per year	Paid in full, up to \$800 per year
DENTISTRY	Not covered	Not covered	Not covered	Not Covered
LIFETIME MAXIMUM	None	None	None	None
EXCLUSIONS	<ul style="list-style-type: none"> Experimental procedures Custodial care Personal comfort items TMJ treatment Treatment for obesity Acupuncture Biofeedback In vitro fertilization Gamete or zygote intrafallopian transfer Artificial insemination Reversal of voluntary sterilization Transsexual surgery Treatment of sexual disorders Cosmetic surgery Laser and radial keratotomy Biofeedback Chiropractic services Private duty nursing Workers' Comp Physical exams for employment or insurance Vision therapy Routine foot care not medically necessary Services for members confined in criminal justice institutions Any treatment not medically necessary Dental care unless within 30 days after an accidental injury to sound natural teeth Hospice care Transplants Emergency transport Skilled nursing facility Autism 	<ul style="list-style-type: none"> Experimental procedures Custodial care Personal comfort items TMJ treatment Treatment for obesity Acupuncture Biofeedback In vitro fertilization Gamete or zygote intrafallopian transfer Artificial insemination Reversal of voluntary sterilization Transsexual surgery Treatment of sexual disorders Cosmetic surgery Laser and radial keratotomy Biofeedback Chiropractic services Private duty nursing Workers' Comp Physical exams for employment or insurance Vision therapy Routine foot care not medically necessary Services for members confined in criminal justice institutions Any treatment not medically necessary Dental care unless within 30 days after an accidental injury to sound natural teeth 	<ul style="list-style-type: none"> Experimental procedures Custodial care Personal comfort items TMJ treatment Treatment for obesity Acupuncture Biofeedback In vitro fertilization Gamete or zygote intrafallopian transfer Artificial insemination Reversal of voluntary sterilization Transsexual surgery Treatment of sexual disorders Cosmetic surgery Laser and radial keratotomy Biofeedback Chiropractic services Private duty nursing Workers' Comp Physical exams for employment or insurance Vision therapy Routine foot care not medically necessary Services for members confined in criminal justice institutions Any treatment not medically necessary Dental care unless within 30 days after an accidental injury to sound natural teeth 	<ul style="list-style-type: none"> Experimental procedures Custodial care Personal comfort items TMJ treatment Treatment for obesity Acupuncture Biofeedback In vitro fertilization Gamete or zygote intrafallopian transfer Artificial insemination Reversal of voluntary sterilization Transsexual surgery Treatment of sexual disorders Cosmetic surgery Laser and radial keratotomy Biofeedback Chiropractic services Private duty nursing Workers' Comp Physical exams for employment or insurance Vision therapy Routine foot care not medically necessary Services for members confined in criminal justice institutions Any treatment not medically necessary Dental care unless within 30 days after an accidental injury to sound natural teeth

Exhibit III

Child Health Plan Plus
Standardized Utilization and Cost Factors

Categories of Basic Services	Standardized Utilization				Standardized Cost			
	0 - 1	2 - 6	7 - 18	Combined	0 - 1	2 - 6	7 - 18	Combined
Inpatient Hospital								
Medical/Surgical	0.6480	0.0795	0.0835	0.1354	\$ 2,618.59	\$ 1,962.05	\$ 2,125.73	\$ 2,131.97
Maternity	0.0000	0.0000	0.0012	0.0007	\$ 1,661.22	\$ 1,661.22	\$ 1,661.22	\$ 1,661.22
Outpatient Hospital								
Emergency Room	0.1705	0.1840	0.1915	0.1875	\$ 285.08	\$ 285.08	\$ 285.08	\$ 285.08
Surgery	0.0409	0.0428	0.0279	0.0331	\$ 2,346.81	\$ 2,346.81	\$ 2,346.81	\$ 2,346.81
Other	0.0000	0.3891	0.1089	0.1711	\$ 176.73	\$ 176.73	\$ 176.73	\$ 176.73
Physician								
Inpatient Surgery	0.0459	0.0094	0.0136	0.0157	\$ 1,229.10	\$ 1,662.66	\$ 1,735.79	\$ 1,666.62
Outpatient Surgery	0.1501	0.1328	0.1831	0.1668	\$ 390.91	\$ 373.60	\$ 235.15	\$ 286.57
Office Visits and Misc	5.8634	3.1907	1.8037	2.5662	\$ 59.74	\$ 58.26	\$ 61.28	\$ 60.34
Hospital Visits	0.5235	0.0593	0.1578	0.1685	\$ 179.78	\$ 153.18	\$ 141.88	\$ 148.57
Emergency Room Visits	0.1744	0.1620	0.1486	0.1547	\$ 125.65	\$ 115.90	\$ 101.22	\$ 107.45
Maternity Care	0.0000	0.0000	0.0004	0.0003	\$ 2,919.51	\$ 2,919.51	\$ 2,919.51	\$ 2,919.51
Other	0.1329	0.0177	0.0154	0.0276	\$ 165.73	\$ 163.84	\$ 167.56	\$ 166.41
Laboratory and X-Ray Services								
Radiology/Pathology Facility Services	0.1323	0.0813	0.0951	0.0952	\$ 376.90	\$ 376.90	\$ 376.90	\$ 376.90
Radiology/Pathology Physician Services	1.7186	1.2825	1.1491	1.2401	\$ 33.26	\$ 37.34	\$ 40.27	\$ 38.81
Well Child Services								
Immunizations	2.9311	1.0148	0.2033	0.6843	\$ 32.55	\$ 32.55	\$ 32.55	\$ 32.55
Well Baby Exams	3.2099	0.0000	0.0000	0.3178	\$ 68.55	\$ 6.46	\$ 68.55	\$ 52.41
Well Child Exams	0.0000	0.1021	0.1500	0.1227	\$ -	\$ 99.58	\$ 149.34	\$ 121.62
Categories of Additional Services								
Prescription Drugs	4.1778	2.8195	1.6975	2.2347	\$ 24.33	\$ 31.00	\$ 42.66	\$ 37.81
Mental Health Services								
Inpatient	0.0000	0.0035	0.0730	0.0477	\$ 1,339.47	\$ 1,339.47	\$ 1,339.47	\$ 1,339.47
Outpatient	0.0000	0.0644	0.2070	0.1494	\$ 128.50	\$ 128.50	\$ 128.50	\$ 128.50
Vision Services								
Vision Exams	0.0248	0.0754	0.1766	0.1353	\$ 74.35	\$ 74.35	\$ 74.35	\$ 74.35
Glasses/Contacts	0.0000	0.0285	0.0699	0.0522	\$ 213.37	\$ 213.37	\$ 213.37	\$ 213.37
Hearing Services								
Hearing Exams	0.0018	0.1003	0.0322	0.0469	\$ 57.59	\$ 57.59	\$ 57.59	\$ 57.59
Hearing Aids	0.0000	0.0070	0.0070	0.0063	\$ 1,000.00	\$ 1,000.00	\$ 1,000.00	\$ 1,000.00
Other Categories of Service								
Substance Abuse inpatient	0.0000	0.0000	0.0206	0.0132	\$ 980.60	\$ 980.48	\$ 980.48	\$ 980.49
Substance Abuse Outpatient	0.0000	0.0000	0.0064	0.0041	\$ 113.40	\$ 113.40	\$ 113.40	\$ 113.40
Skilled Nursing Facility	0.0000	0.0000	0.0011	0.0007	\$ 406.31	\$ 406.31	\$ 406.31	\$ 406.31
Chiropractor	0.0187	0.0383	0.1380	0.1002	\$ 64.38	\$ 64.38	\$ 64.38	\$ 64.38
Physical Therapy	0.0454	0.0757	0.0774	0.0738	\$ 68.16	\$ 68.16	\$ 68.16	\$ 68.16
Home Health	0.0175	0.0331	0.0092	0.0162	\$ 278.50	\$ 278.50	\$ 278.50	\$ 278.50
Ambulance	0.0212	0.0064	0.0074	0.0085	\$ 393.48	\$ 393.48	\$ 393.48	\$ 393.48
Durable Medical Equipment	0.0405	0.0221	0.0221	0.0239	\$ 328.93	\$ 328.93	\$ 328.93	\$ 328.93
Audiology Exams	0.0000	0.0018	0.0018	0.0017	\$ 91.93	\$ 93.43	\$ 115.67	\$ 107.54
Dental Care	0.0000	3.0010	3.0010	2.7939	\$ 72.74	\$ 72.74	\$ 72.74	\$ 72.74

Child Health Plan Plus
Standardized Population

Age	Projected 1997 Colorado Population
0	53,107
1	52,777
2	54,040
3	54,375
4	55,875
5	57,106
6	57,295
7	57,769
8	54,393
9	57,578
10	58,257
11	57,685
12	57,100
13	56,528
14	57,943
15	58,539
16	57,654
17	58,276
18	53,920
Total	1,070,217

Note: For children with family income up to 100% of the Federal Poverty Level, there is no cost-sharing.

	DESCRIPTION OF BENEFIT	COPAY	
		101-150% FPL	151 -185% FPL
1. ANNUAL DEDUCTIBLE Individual Family	Not applicable.	None.	None.
2. OUT-OF-POCKET MAXIMUM Inpatient Family	Maximum amount enrollee has to pay out of pocket in any one year for covered benefits.	5% of annual family income adjusted for family size.	5% of annual family income adjusted for family size.
3. HOSPITAL EMERGENCY ROOM AND EMERGENCY TRANSPORT ¹	Covered.	\$6. Waived with hospital admission.	\$6. Waived with hospital admission.
4. INPATIENT	Covered.	\$0	\$0
5. OUTPATIENT/ AMBULATORY SURGERY	Covered.	\$0	\$0
6. MEDICAL OFFICE VISIT (including physician, mid-level practitioner, & specialist visits) ²	Covered.	\$2	\$5
7. LABORATORY & X-RAY SERVICES	Covered.	\$0	\$0
8. PREVENTATIVE CARE	Covered. Same benefits as mandated under the Standard Health Benefit Plan and as recommended by the American Academy of Pediatrics (e.g. immunizations, well-child visits and health maintenance visits.)	\$0	\$0

¹ In accordance with Title XIX, the co-pay is waived if the visit is an emergency.

² If the carrier includes School-Based Health Centers in its provider network it may waive the medical office visit copay for visits at School Based Health Centers.

		101-150% FPL	151 -185% FPL
9. MATERNITY CARE Prenatal	Covered.	\$0	\$0
Delivery & inpatient well baby care	Covered. State law requires infant to be covered for first 30 days.	\$0	\$0
10. NEUROBIOLOGICALLY- BASED MENTAL ILLNESSES (EFFECTIVE 1/98) ³	Covered, Treated the same as any other mental health condition (e.g. there are no limits on the number of hospital days covered.)	\$2/office visit; \$0/admission	\$5/office visit; \$0/admission
11. ALL OTHER MENTAL HEALTH ⁴ Institutional care (Maximum 45 inpatient or 90 partial days/year)	Limited coverage. 45 days of inpatient coverage with the option of converting 45 inpatient days into 90 days of day treatment services. ⁵	\$0	\$0
Outpatient care	Limited coverage. 20 visit limit.	\$2	\$5
12. ALCOHOL & SUBSTANCE ABUSE	Limited coverage. 20 visit limit.	\$2	\$5
13. PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY	Limited coverage. 30 visits per diagnosis per year,	\$2	\$5
14. DURABLE MEDICAL EQUIPMENT	Limited coverage. Maximum \$2,000/year paid by plan. Coverage for lesser of purchase price or rental price for medically necessary durable medical equipment, including home administered oxygen.	\$0	\$0
15. ORGAN TRANSPLANTS	Limited coverage. Will include those transplants covered by the Standard Plan including liver, heart, heart/lung, cornea, kidney, and bone marrow for aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and stage III breast cancer, and Wiskott Aldrich syndrome only. Peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants. Transplants will be covered only if they are medically necessary and the facility meets clinical standards for the procedure.	\$0	\$0

³ Requires the following to be treated as any other illness or condition: schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive compulsive disorder, and panic disorder. Applies to all group health benefit plans.

⁴ All other mental health benefits include coverage for all mental health conditions recognized in the DSM-IV manual.

⁵ This recognizes that as in all HMOs, the HMO has the right to exempt clients from this limit.

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		101-150% FPL	151 -185% FPL
16. HOME HEALTH CARE	Covered.	\$0	\$0
17. HOSPICE CARE	Covered.	\$0	\$0
18. OUTPATIENT PRESCRIPTION DRUGS	Covered.	\$1	\$3 - generic. \$5 - brand name.
19. SKILLED NURSING FACILITY CARE	Covered.	\$0	\$0
20. VISION SERVICES	Limited coverage. Vision screenings are covered as age appropriate preventive care. Referral required for refraction services. \$50 annual benefit for eyeglasses.	\$2 for referral and refraction benefits only	\$5 for referral and refraction benefits only
21. AUDIOLOGICAL SERVICES	Limited coverage. Hearing screenings are covered as age appropriate preventive care. Hearing aides covered for congenital and traumatic injury; maximum \$800/year paid by plan.	\$0	\$0
22. DENTISTRY	Not covered.	-	-
23. INTRACTABLE PAIN	Covered. Included as a benefit with the medical office visit copay.	Treated the same as any other medical condition	Treated the same as any other medical condition
24. AUTISM COVERAGE	Covered. Included as a benefit with the medical office visit copay.	Treated the same as any other medical condition	Treated the same as any other medical condition
25. CASE MANAGEMENT	Not covered. ⁶	Not applicable.	Not applicable.
26. NUTRITION SERVICES	Limited coverage. Formula for metabolic disorders, total parenteral nutrition, enterals and nutrition products, and formulas for gastrostomy tubes are covered for people with documented medical need. Documentation includes prior authorization which lists medical condition including gastrointestinal disorders, malabsorption syndromes or a condition that affects normal growth patterns or the normal absorption of nutrition. ⁷	\$0	\$0
27. LIFETIME MAXIMUM	Not applicable.	None.	None.
28. PRE-EXISTING CONDITION LIMITATIONS	No pre-existing condition limitations.	Not applicable.	Not applicable.

⁶ Contract language will specify areas of medical case management for which plans will be required to provide services.

⁷ The committee's intent is for this service not to be abused. Rather, when a nutrition service is medically necessary, it should be utilized.

29. EXCLUSIONS	Experimental procedures, custodial care, personal comfort items, TMJ treatment, treatment for obesity, acupuncture, biofeedback, chiropractic, in vitro fertilization, gamete or zygote intrafallopian transfer, artificial insemination, reversal of voluntary sterilization, transsexual surgery, treatment of sexual disorders, cosmetic surgery, radial keratotomy, biofeedback, chiropractic services, private duty nursing, workers compensation, physical exams for employment of insurance, vision therapy (e.g. muscle exercises), routine foot care not medically necessary, services for members confined in criminal justice institutions and any treatment not medically necessary.	101-150% FPL Not applicable.	151 -185% FPL Not applicable.
30. ADDITIONAL POLICY ISSUES	A. DEFINITION OF MEDICAL NECESSITY Committee agreed that in specifying elements of medical necessity, the recommendations of the American Academy of Pediatrics will serve as basis for the medical necessity definition.		

Children's Basic Health Plan Benefits—FFS

Note: For children with family income up to 100% of the Federal Poverty Level, there is no cost-sharing.

	DESCRIPTION OF BENEFIT	COPAY
1. ANNUAL DEDUCTIBLE Individual Family	Not applicable.	None. None.
2. OUT-OF-POCKET MAXIMUM Inpatient Family	Maximum amount enrollee has to pay out of pocket in any one year for covered benefits.	5% of annual family income adjusted for family size.
3. HOSPITAL EMERGENCY ROOM AND TRANSPORT ¹	Covered.	None.
4. INPATIENT	Covered.	\$0
5. OUTPATIENT/ AMBULATORY SURGERY	Covered.	\$0
6. MEDICAL OFFICE Visit (including physician, mid-level practitioner, & specialist visits) ²	Covered.	\$2
7. LABORATORY & X- RAY SERVICES	Covered.	\$0
8. PREVENTATIVE CARE	Covered. Same benefits as mandated under the Standard Health Benefit Plan and as recommended by the American Academy of Pediatrics (e.g. immunizations, well-child visits and health maintenance visits.)	\$0
9. MATERNITY CARE Prenatal Delivery & inpatient well baby care	Covered. Covered. State law requires infant to be covered for first 30 days.	\$0 \$0

¹ In accordance with Title XIX, this co-pay is waived if the visit is an emergency.

² If the carrier includes School-Based Health Centers in its provider network it may waive the medical office visit copay for visits at School Based Health Centers.

	DESCRIPTION OF BENEFIT	COPAY
10. NEUROBIOLOGICALLY-BASED MENTAL ILLNESSES (EFFECTIVE 1/98) ³	Covered. Treated the same as any other mental health condition (e.g. there are no limits on the number of hospital days covered.)	\$2/office visit, \$0/admission
11. ALL OTHER MENTAL HEALTH ⁴ Institutional care (Maximum 45 inpatient or 90 partial days/year) Outpatient care	Limited coverage. 45 days of inpatient coverage with the option of converting 45 inpatient days into 90 days of day treatment services. ⁵ Limited coverage. 20 visit limit.	\$0 \$2
12. ALCOHOL & SUBSTANCE ABUSE	Limited coverage. 20 visit limit.	\$2
13. PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY	Limited coverage. 30 visits per diagnosis per year.	\$2
14. DURABLE MEDICAL EQUIPMENT	Limited coverage. Maximum \$2,000/year paid by plan. Coverage for lesser of purchase price or rental price for medically necessary durable medical equipment, including home administered oxygen.	\$0
15. HOME HEALTH CARE	Covered.	\$0
16. OUTPATIENT PRESCRIPTION DRUGS	Covered.	\$1
17. VISION SERVICES	Limited coverage. Vision screenings are covered as age appropriate preventive care. Referral required for refraction services. \$50 annual benefit for eyeglasses.	\$2 for referral and refraction benefits only
18. AUDIOLOGICAL SERVICES	Limited coverage. Hearing screenings are covered as age appropriate preventive care. Hearing aids covered for congenital and traumatic injury; maximum \$800/year paid by plan.	\$0
19. DENTISTRY	Not covered.	-

³ Requires the following to be treated as any other illness or condition: schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive compulsive disorder, and panic disorder. Applies to all group health benefit plans.

⁴ All other mental health benefits include coverage for all mental health conditions recognized in the DSM-IV manual.

⁵ This recognizes that as in all HMOs, the HMO has the right to exempt clients from this limit.

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	DESCRIPTION OF BENEFIT	COPAY	
20. INTRACTABLE PAIN	Covered. Included as a benefit with the medical office visit copay.	Treated the same as any other medical condition	
21. CASE MANAGEMENT	Not covered. ⁶	Not applicable.	Not applicable.
22. NUTRITION SERVICES	Limited coverage. Formula for metabolic disorders, total parenteral nutrition, enterals and nutrition products, and formulas for gastrostomy tubes are covered for people with documented medical need. Documentation includes prior authorization which lists medical condition including gastrointestinal disorders, malabsorption syndromes or a condition that affects normal growth patterns or the normal absorption of nutrition. ⁷	\$0	
23. LIFETIME MAXIMUM	Not applicable.	None.	
24. PRE-EXISTING CONDITION LIMITATIONS	No pre-existing condition limitations.	Not applicable.	
25. EXCLUSIONS	Experimental procedures, custodial care, personal comfort items, TMJ treatment, treatment for obesity, acupuncture, biofeedback, chiropractic, in vitro fertilization, gamete or zygote intrafallopian transfer, artificial insemination, reversal of voluntary sterilization, transsexual surgery, treatment of sexual disorders, cosmetic surgery, radial keratotomy, biofeedback, chiropractic services, private duty nursing, workers compensation, physical exams for employment of insurance, vision therapy (e.g. muscle exercises), organ transplants, skilled nursing facility, autism, hospice, routine foot care not medically necessary, services for members confined in criminal justice institutions and any treatment not medically necessary.	Not applicable.	
26. ADDITIONAL POLICY ISSUES			
A. DEFINITION OF MEDICAL NECESSITY	Committee agreed that in specifying elements of medical necessity, the recommendations of the American Academy of Pediatrics will serve as basis for the medical necessity definition.		

⁶ Contract language will specify areas of medical case management for which plans will be required to provide services.

⁷ The committee's intent is for this service not to be abused. Rather, when a nutrition service is medically necessary, it should be utilized.

**Children's Basic Health Plan
Benefit Design and Pricing Committee Recommendation for
Premium Cost-Sharing**

Federal Poverty Level	Number of Children	
	One Child	Two or more children
Under 63% FPL	Waived	Waived
63%-81% FPL	Waived	Waived
82%-100% FPL	Waived	Waived
101%-150% FPL	\$9/child/month	\$15/family/month
151%-169% FPL	\$15/child/month	\$25/family/month
170%-185% FPL	\$20/child/month	\$30/family/month
Over 186 % FPL	\$68/child/month	\$68/child/month

1997 Federal Poverty Levels

	Annual Family Income: 1 adult + 1 child	Annual Family Income: 1 adult + 2 children
63% FPL	\$6,684	\$8,398
81% FPL	\$8,594	\$10,797
100% FPL	\$10,610	\$13,330
150% FPL	\$15,915	\$19,995
170% FPL	\$18,037	\$22,661
185% FPL	\$19,629	\$24,661

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SOURCES OF NON-FEDERAL SHARE OF EXPENDITURES

The Child Health Plan Plus operations will be funded from three primary sources: state General Fund, CHP cash reserves, and donations. The following paragraphs describe the origin and amount of each of these funding sources.

Colorado Child Health Plan Plus			
Sources of Non-Federal Funding SFY98-00			
	SFY97-98	SFY98-99	SFY99-00
Medicaid Managed Care Savings	\$ -	\$1,196,881	\$6,570,015
CHP General Fund appropriation	\$1,013,598	\$1,013,598	\$1,013,598
One-time General Fund appropriation	\$2,000,000	\$ -	\$ -
Private Grants	\$135,000	\$110,676	\$ -
University Hospital Intergovernmental Transfer	\$650,000	\$650,000	\$ 650,000
CHP Cash Reserves	\$1,970,482	\$ -	\$ -
Total State and Private Funding Available	\$5,769,080	\$2,971,155	\$8,233,613
Less state-only expenditures for children receiving non-comprehensive benefits	(\$2,796,406)	(\$588,954)	\$ -
Less carryover of funding in Trust	(\$1,400,000)	\$1,400,000	\$ -
Total Non-Federal Funding	\$1,572,674	\$3,782,201	\$8,233,613

State General Fund

Medicaid Managed Care Savings

State General Fund

Medicaid Managed Care Savings

The state law (C.R.S. 26-4-113(7)(c)) expresses the intent that a portion of the general fund share of the savings realized from increased enrollment of Medicaid clients into managed care be appropriated to the Children’s Basic Health Plan. Medicaid clients who enroll in managed care choose between the Primary Care Physician Program (PCP) and Health Maintenance Organizations (HMOs). HMOs are paid a capitated rate which the Department sets at 95% of fee-for service costs. In other words, for each client enrolled in an HMO, the Department realizes a 5% per capita savings.

Colorado Child Health Plan State General Fund Appropriation

The Colorado Child Health Plan currently receives a state General Fund appropriation of \$1,013,598.

One-time General Fund Appropriation

House Bill 97-1304 created the Children’s Basic Health Plan Trust and included a one-time \$2 million General Fund to the Trust to fund the expansion of the Colorado Child Health Plan and the start-up costs of the Children’s Basic Health Plan. Enrollment is limited below available funding in SFY97-98 to allow funds to be carried over to SFY98-99 to maintain SFY98-99 enrollment levels. In general, any unspent funds held in the Trust do not revert back to the General Fund at the end of the state fiscal year and can be carried forward to be spent in future years.

Donations

University Hospital

University Hospital provides for an intergovernmental transfer in the amount of \$650,000 to the Colorado Child Health Plan each year.

Private Foundations

Local foundations have contributed \$135,000 in private funds to support the start-up costs of the Children’s Basic Health Plan. These commitments include \$90,000 from the Colorado Foundation, \$20,000 from the Piton Foundation, and \$25,000 from the Denver Foundation. In addition, the Department of Health Care Policy and Financing has applied for \$110,676 under the Robert Wood Johnson’s Healthy Kids Replication Program.

Colorado Child Health Plan Cash Reserves

At the beginning of SFY97-98, the Colorado Child Health Plan held \$1,970,482 in cash reserves. This reserve includes University Hospital intergovernmental transfers made to the CHP that could not be spent in previous years.